FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0027870

Facility Name: ST AGNES MANOR INC.

Address: 1721 S. WABASH (Number) CHICAGO (City) 60616 (Zip Code)

County: COOK

Telephone Number: (312) 787-9400 **Fax #** (312) 787-9590

IDPA ID Number: 363192742001

Date of Initial License for Current Owners: 07/26/83

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) JEFFREY K. SINGER, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	171	Skilled (SNF)	171	62,415	1
2		Skilled Pediatric (SNF/PED)			2
3	26	Intermediate (ICF)	26	9,490	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	197	TOTALS	197	71,905	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	51,238	3,216	5,199	59,653	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	3,432			3,432	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	54,670	3,216	5,199	63,085	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.73%

D. How many bed-hold days during this year were paid by Public Aid?
243 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 8/1/1983

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 1983 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 26 and days of care provided 5167

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary		35,101	403,544	438,645		438,645		438,645			1
2	Food Purchase		446,750		446,750	(51,626)	395,124	(227)	394,898			2
3	Housekeeping	20,524	43,655	340,047	404,226		404,226		404,226			3
4	Laundry		61,614	127,038	188,652		188,652		188,652			4
5	Heat and Other Utilities			199,657	199,657		199,657	1,956	201,613			5
6	Maintenance	82,305		294,062	376,367		376,367	(17,156)	359,211			6
7	Other (specify):*											7
8	**TOTAL General Services**	102,829	587,120	1,364,348	2,054,297	(51,626)	2,002,671	(15,427)	1,987,245			8
	B. Health Care and Programs											
9	Medical Director			5,040	5,040		5,040		5,040			9
10	Nursing and Medical Records	1,043,057	30,814	1,512,436	2,586,307		2,586,307		2,586,307			10
10a	Therapy	95,623		19,390	115,013		115,013		115,013			10a
11	Activities	273,203	14,232	40,012	327,447		327,447		327,447			11
12	Social Services	102,217		41,454	143,671		143,671		143,671			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,514,100	45,046	1,618,332	3,177,478		3,177,478		3,177,478			16
	C. General Administration											
17	Administrative			620,000	620,000		620,000	(493,181)	126,819			17
18	Directors Fees											18
19	Professional Services			74,463	74,463	(38,556)	35,907	8,185	44,092			19
20	Dues, Fees, Subscriptions & Promotions			26,636	26,636		26,636	(3,107)	23,529			20
21	Clerical & General Office Expenses	43,149	39,414	156,862	239,425		239,425	126,263	365,688			21
22	Employee Benefits & Payroll Taxes			186,492	186,492	51,626	238,118		238,118			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,119	1,119		1,119	126	1,245			24
25	Other Admin. Staff Transportation			876	876		876	3,525	4,401			25
26	Insurance-Prop.Liab.Malpractice			110,604	110,604		110,604	4,575	115,179			26
27	Other (specify):*							32,078	32,078			27
28	**TOTAL General Administration**	43,149	39,414	1,177,052	1,259,615	13,070	1,272,685	(321,536)	951,149			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,660,078	671,580	4,159,732	6,491,390	(38,556)	6,452,834	(336,963)	6,115,871			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number ST AGNES MANOR INC. #0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			83,710	83,710		83,710	145,750	229,460			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,318	3,318		3,318	293,143	296,461			32
33	Real Estate Taxes			223,315	223,315	38,556	261,871	3,500	265,371			33
34	Rent-Facility & Grounds			451,196	451,196		451,196	(451,196)				34
35	Rent-Equipment & Vehicles			14,004	14,004		14,004		14,004			35
36	Other (specify):*											36
37	TOTAL Ownership			775,543	775,543	38,556	814,099	(8,803)	805,296			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	36,404	383,948	157,210	577,562		577,562		577,562			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			9,813	9,813		9,813	(1,154)	8,659			41
42	Provider Participation Fee			107,857	107,857		107,857		107,857			42
43	Other (specify):*			366	366		366	(366)				43
44	TOTAL Special Cost Centers	36,404	383,948	275,246	695,598		695,598	(1,520)	694,078			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,696,482	1,055,528	5,210,521	7,962,531		7,962,531	(347,286)	7,615,245			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	111,717	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(227)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(825)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(9,814)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,373)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(227,578)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (128,100)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(219,186)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (219,186)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (347,286)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

ST AGNES MANOR INC.

ID# 0027870

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Capitalized Repairs and Maintenance	$ (25,528)	06	1
2	Collections	(80)	21	2
3	Fines	(375)	21	3
4	Trust Fees	(435)	20	4
5	Misc. Expense	(81)	21	5
6	Nonallowable Seminar	(366)	43	6
7	Vending Income	(1,154)	41	7
8	Bldg. Company Professional Fees	(2,255)	19	8
9	Rent Expense overstated in prior year	(197,304)	34	9
10				10
11				11
12				12
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STATE OF ILLINOIS

Summary A

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(227)											(227)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			1,956									1,956	5
6	Maintenance	(25,528)		8,372									(17,156)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(25,755)		10,328									(15,427)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records													10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**													16
	C. General Administration													
17	Administrative			(620,000)	65,611	61,208							(493,181)	17
18	Directors Fees													18
19	Professional Services	(2,255)	2,255	8,185									8,185	19
20	Fees, Subscriptions & Promotions	(11,074)	50	7,917									(3,107)	20
21	Clerical & General Office Expenses	(1,909)		128,172									126,263	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar			126									126	24
25	Other Admin. Staff Transportation			3,525									3,525	25
26	Insurance-Prop.Liab.Malpractice			4,575									4,575	26
27	Other (specify):*			21,517	5,216	5,345							32,078	27
28	**TOTAL General Administration**	(15,238)	2,305	(445,983)	70,827	66,553							(321,536)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(40,993)	2,305	(435,655)	70,827	66,553							(336,963)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	111,717	26,813	7,220									145,750	30
31	Amortization of Pre-Op. & Org.													31
32	Interest		271,196	21,947									293,143	32
33	Real Estate Taxes			3,500									3,500	33
34	Rent-Facility & Grounds	(197,304)	(253,892)										(451,196)	34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	**TOTAL Ownership**	(85,587)	44,117	32,667									(8,803)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops	(1,154)											(1,154)	41
42	Provider Participation Fee													42
43	Other (specify):*	(366)											(366)	43
44	**TOTAL Special Cost Centers**	(1,520)											(1,520)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(128,100)	46,422	(402,988)	70,827	66,553							(347,286)	45

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
PETER O'BRIEN	60.00%	SEE ATTACHED		SEE ATTACHED		
DANIEL O'BRIEN	20.00%					
MARY O'BRIEN	20.00%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENTAL INCOME	$ 253,892	1721 CORPORATION	100.00%	$	$ (253,892)	1
2	V	30	DEPRECIATION		1721 CORPORATION		26,813	26,813	2
3	V	20	LICENSES AND FEES		1721 CORPORATION		50	50	3
4	V	19	PROFESSIONAL FEES		1721 CORPORATION		2,255	2,255	4
5	V	32	INTEREST EXPENSE		1721 CORPORATION		271,196	271,196	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 253,892			$ 300,314	$ * 46,422	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	MADO MGMT. LP	100.00%	$ 1,956	$ 1,956	15
16	V	6	REPAIRS AND MAINT.				8,372	8,372	16
17	V	19	PROFESSIONAL FEES				8,185	8,185	17
18	V	20	DUES AND SUBSCRIPTIONS				7,917	7,917	18
19	V	21	CLERICAL AND GENERAL				128,172	128,172	19
20	V	24	SEMINARS				126	126	20
21	V	25	AUTO EXPENSE				3,525	3,525	21
22	V	26	PROPERTY INSURANCE				4,575	4,575	22
23	V	27	GEN. ADMIN. - EMP. BEN.				21,517	21,517	23
24	V	30	DEPRECIATION				7,220	7,220	24
25	V	32	INTEREST				21,947	21,947	25
26	V	33	REAL ESTATE TAXES				3,500	3,500	26
27	V								27
28	V								28
29	V	17	MANAGEMENT FEES	620,000				(620,000)	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 620,000			$ 217,012	$ * (402,988)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	SALARY-D. O'BRIEN	$	MADO MGMT. LP	100.00%	$ 6,250	$ 6,250	15
16	V	27	EMP. BEN.-D. O'BRIEN				1,425	1,425	16
17	V								17
18	V	17	SALARY-P. O'BRIEN				36,250	36,250	18
19	V	27	EMP. BEN.-P. O'BRIEN				1,823	1,823	19
20	V								20
21	V	17	SALARY-C. STUMPF				23,111	23,111	21
22	V	27	EMP. BEN.-C. STUMPF				1,968	1,968	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 70,827	$ * 70,827	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	MADO MGMT. LP	100.00%	$	$	15
16	V	6	REPAIRS AND MAINTENANCE						16
17	V	17	ADMINISTRATIVE SALARY				61,208	61,208	17
18	V	21	CLERICAL SALARY						18
19	V	27	GEN. ADMIN. - EMP. BEN.				5,345	5,345	19
20	V	30	DEPRECIATION-WAREHOUSE						20
21	V	33	REAL ESTATE TAXES						21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 66,553	$ * 66,553	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	DIETARY	$ 34,505	WINDY CITY NURSING	100.00%	$ 34,505	$	15
16	V	03	HOUSEKEEPING	340,047	WINDY CITY NURSING	100.00%	340,047		16
17	V	04	LAUNDRY	127,038	WINDY CITY NURSING	100.00%	127,038		17
18	V	06	MAINTENANCE	174,720	WINDY CITY NURSING	100.00%	174,720		18
19	V	10	NURSING	1,507,804	WINDY CITY NURSING	100.00%	1,507,804		19
20	V	11	ACTIVITY	37,615	WINDY CITY NURSING	100.00%	37,615		20
21	V	12	SOCIAL SERVICES	38,006	WINDY CITY NURSING	100.00%	38,006		21
22	V	21	OFFICE	131,201	WINDY CITY NURSING	100.00%	131,201		22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 2,390,936			$ 2,390,936	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	39	MEDICAL SUPPLIES	$ 41,681	ST. AGNES MEDICAL EQUIPMENT	100.00%	$ 41,681	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 41,681			$ 41,681	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	DANIEL O'BRIEN	OWNER	Dir. Of Operation	20.00%	SEE ATTACHED	6	15.00%	Alloc. Salary	$ 6,250	17-7	1
2											2
3	PETER O'BRIEN	OWNER	Administrative	60.00%	SEE ATTACHED	6	10.00%	Alloc. Salary	36,250	17-7	3
4	CHARLES STUMPF	RELATIVE	Administrative		SEE ATTACHED	8	17.78%	Alloc. Salary	23,111	17-7	4
5	JAMES WEST	RELATIVE	Clerical		SEE ATTACHED	10.7	26.75%	Alloc. Salary	14,679	21-7	5
6	KATHLEEN STUMPF	RELATIVE	Administrative		SEE ATTACHED	5	11.11%				6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 80,290		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MADO MGMT. LP
Street Address: 1541 N. WELLS ST.
City / State / Zip Code: CHICAGO, IL. 60610
Phone Number: (312) 787-9400
Fax Number: (312) 787-9434

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	236,364	5	$ 7,328	$	63,085	$ 1,956	1
2	6	REPAIRS AND MAINT.	PATIENT DAYS	236,364	5	31,369		63,085	8,372	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	236,364	5	30,669		63,085	8,185	3
4	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	236,364	5	29,662		63,085	7,917	4
5	21	CLERICAL AND GENERAL	PATIENT DAYS	236,364	5	480,229	393,151	63,085	128,172	5
6	24	SEMINARS	PATIENT DAYS	236,364	5	473		63,085	126	6
7	25	AUTO EXPENSE	PATIENT DAYS	236,364	5	13,206		63,085	3,525	7
8	26	PROPERTY INSURANCE	PATIENT DAYS	236,364	5	17,140		63,085	4,575	8
9	27	GEN. ADMIN. - EMP. BEN.	PATIENT DAYS	236,364	5	80,619		63,085	21,517	9
10	30	DEPRECIATION	PATIENT DAYS	236,364	5	27,053		63,085	7,220	10
11	32	INTEREST	PATIENT DAYS	236,364	5	82,230		63,085	21,947	11
12	33	REAL ESTATE TAXES	PATIENT DAYS	236,364	5	13,113		63,085	3,500	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 813,091	$ 393,151		$ 217,012	25

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MADO MGMT. LP
Street Address: 1541 N. WELLS ST.
City / State / Zip Code: CHICAGO, IL. 60610
Phone Number: (312) 787-9400
Fax Number: (312) 787-9434

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	SALARY-D. O'BRIEN	AVG. HOURS WORKED	24	5	25,000	25,000	6	6,250	1
2	27	EMP. BEN.-D. O'BRIEN	AVG. HOURS WORKED	24	5	5,698		6	1,425	2
3										3
4	17	SALARY-P. O'BRIEN	AVG. HOURS WORKED	45	5	271,875	271,875	6	36,250	4
5	27	EMP. BEN.-P. O'BRIEN	AVG. HOURS WORKED	45	5	13,673		6	1,823	5
6										6
7	17	SALARY-C. STUMPF	AVG. HOURS WORKED	45	5	130,000	130,000	8	23,111	7
8	27	EMP. BEN.-C. STUMPF	AVG. HOURS WORKED	45	5	11,070		8	1,968	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 457,316	$ 426,875		$ 70,827	25

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MADO MGMT. LP
Street Address: 1541 N. WELLS ST.
City / State / Zip Code: CHICAGO, IL. 60610
Phone Number: (312) 787-9400
Fax Number: (312) 787-9434

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	DIRECT ALLOCATION		1	2,669				1
2	6	REPAIRS AND MAINTENANCE	DIRECT ALLOCATION		1	20				2
3	17	ADMINISTRATIVE SALARY	DIRECT ALLOCATION		5	311,812	311,812		61,208	3
4	21	CLERICAL SALARY	DIRECT ALLOCATION		2	89,754	89,754			4
5	27	GEN. ADMIN. - EMP. BEN.	DIRECT ALLOCATION		5	50,832			5,345	5
6	30	DEPRECIATION-WAREHOUSE	DIRECT ALLOCATION		1	1,082				6
7	33	REAL ESTATE TAXES	DIRECT ALLOCATION		1	1,810				7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 457,979	$ 401,566		$ 66,553	25

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Windy City Nursing
Street Address: 1541 N. Wells
City / State / Zip Code: Chicago, IL 60610
Phone Number: (312) 787-9400
Fax Number: (312) 787-9434

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	DIRECT ALLOC.			$	$		$ 34,505	1
2	3	HOUSEKEEPING	DIRECT ALLOC.						340,047	2
3	4	LAUNDRY	DIRECT ALLOC.						127,038	3
4	6	MAINTENANCE	DIRECT ALLOC.						174,720	4
5	10	NURSING	DIRECT ALLOC.						1,507,804	5
6	11	ACTIVITY	DIRECT ALLOC.						37,615	6
7	12	SOCIAL SERVICES	DIRECT ALLOC.						38,006	7
8	21	OFFICE	DIRECT ALLOC.						131,201	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 2,390,936	25

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ST. AGNES MEDICAL EQUIPMENT
Street Address: 1541 N. WELLS
City / State / Zip Code: CHICAGO, IL 60610
Phone Number: (312) 787-9400
Fax Number: (312) 787-9434

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	39	MEDICAL SUPPLIES	DIRECT ALLOC			$	$		$ 41,681	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 41,681	25

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	DANIEL O'BRIEN	X		WORKING CAPITAL				5,237,762				6
7	TIFCO		X	INSURANCE FINANCING							3,318	7
8												8
9	TOTAL Facility Related						$	$ 5,237,762			$ 3,318	9
	B. Non-Facility Related*											
10	See Supplemental Schedule							2,961,622			293,143	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$ 2,961,622			$ 293,143	14
15	TOTALS (line 9+line14)						$	$ 8,199,384			$ 296,461	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	ALLOC-MADO	X					$	$			$ 21,947	1
2	EXCHANGE BANK		X	WORKING CAPITAL				8,000				2
3	BUILDING COMPANY	X		WORKING CAPITAL				2,953,622			271,196	3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$ 2,961,622			$ 293,143	21

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 250,408	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 234,584	2
3. Under or (over) accrual (line 2 minus line 1).		$ (15,824)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 242,639	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$ 38,556	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 265,371	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	245,628	8
	1997	231,157	9
	1998	245,703	10
	1999	240,677	11
	2000	231,084	12

2001 accrual = 2000 tax x 1.05
231,084 x 1.05 = 242639
line 2 includes $3,500 allocation from related party

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ST AGNES MANOR INC. COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0027870

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	17-22-301-014	Long Term Care	$ 10,014.36	$ 10,014.36
2.	17-22-301-015	Long Term Care	$ 28,827.13	$ 28,827.13
3.	17-22-301-016	Long Term Care	$ 121,770.83	$ 121,770.83
4.	17-22-301-017	Long Term Care	$ 58,600.96	$ 58,600.96
5.	17-22-301-050	Long Term Care	$ 11,870.55	$ 11,870.55
6.	17-04-204-012	Allocated - Related Party	$ 19,284.33	$ 3,499.92
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 250,368.16	$ 234,583.75

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 68,975 B. General Construction Type: Exterior MASONRY Frame STEEL Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

none

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	31,879		$ 75,250	1
2					2
3	TOTALS	31,879		$ 75,250	3

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	197		1983	1983	$ 424,750	$	35	$	$	$ 424,750	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1983	1,402,995		20	70,150	70,150	1,235,915	9
10	Various			1984	132,601		20	6,630	6,630	118,766	10
11	Various			1986	21,150		20	-		21,150	11
12	Various			1987	10,000		20	500	(500)	8,836	12
13	Various			1989	72,045		20	3,603	3,603	37,097	13
14	Various			1990	150,700		20	7,329	7,329	70,284	14
15	Various			1991	37,665		20	1,883	1,883	16,854	15
16	Various			1992	45,688		20	2,285	2,285	13,750	16
17	Various			1993	56,127		20	2,806	2,806	18,981	17
18	Various			1994	133,605		20	6,681	6,681	43,150	18
19	Various			1995	204,001		20	10,200	10,200	64,819	19
20	Various			1996	195,571		20	9,782	9,782	53,196	20
21	Various			1997	264,822		20	13,243	13,243	59,840	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		82,192	2,829		2,908	79	19,068	68
69	Financial Statement Depreciation			61,974			(61,974)		69
70	TOTAL (lines 4 thru 69)		$ 3,233,912	$ 64,803		$ 138,000	$ 72,197	$ 2,206,456	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,233,912	$ 64,803		$ 138,000	$ 73,197	$ 2,206,456	1
2	Architect Fees	1998	3,031		20	152	152	469	2
3	DOOR REPAIR	1998	1,450		20	73	73	292	3
4	PIPE REPAIR	1998	4,370		20	219	219	876	4
5	BOILER REPAIR	1998	1,080		20	54	54	216	5
6	DOOR REPAIR	1998	795		20	40	40	160	6
7	DOOR REPAIR	1998	864		20	43	43	172	7
8	NURSE CALL SYSTEM	1998	2,811		20	141	141	564	8
9	PLUMBING WORK	1998			20				9
10	AIR COMPRESSOR	1998	540		20	27	27	106	10
11	PLASTERBOARD/STUDS	1998	4,217		20	211	211	826	11
12	GATE INSTALLATION	1998	600		20	30	30	115	12
13	INDUCER MOTOR	1998	540		20	27	27	104	13
14	PLASTERBOARD	1998	750		20	38	38	146	14
15	SMOKE DETECTION SYST	1998	1,920		20	96	96	368	15
16	FIREGUARDS	1998	2,216		20	111	111	416	16
17	FIREGUARDS	1998	2,075		20	104	104	381	17
18	FIREGUARDS	1998	2,478		20	124	124	455	18
19	DRAIN MAINTENANCE	1998	986		20	49	49	180	19
20	SCAFFOLDING	1998	3,844		20	192	192	688	20
21	FIREGUARDS	1998	2,348		20	117	117	419	21
22	FLOOR FLANGE/TILES	1998	2,224		20	111	111	398	22
23	DOOR/A/C/GATE REPAIR	1998	1,162		20	58	58	203	23
24	GRAVEL/LIMESTONE	1998	795		20	40	40	140	24
25	FIRE GUARDS	1998	2,374		20	119	119	417	25
26	MOTOR	1998	560		20	28	28	98	26
27	FIRE GUARDS	1998	3,561		20	178	178	608	27
28	FIREGUARDS	1998	1,461		20	73	73	249	28
29	ROOFTOP CHILLER	1998	1,225		20	61	61	203	29
30	FAN COIL	1998	1,196		20	60	60	200	30
31	CEILING TILES	1998	2,751		20	138	138	460	31
32	6 MOTORS	1998	645		20	32	32	104	32
33	DRYER EXHAUST	1998	2,500		20	125	125	406	33
34	TOTAL (lines 1 thru 33)		$ 3,291,281	$ 64,803		$ 140,871	$ 76,068	$ 2,216,895	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,291,281	$ 64,803		$ 140,871	$ 76,068	$ 2,216,895	1
2	PIPES	1998	2,665		20	133	133	421	2
3	GAS LINE	1998	1,708		20	85	85	262	3
4	DOOR REPAIR	1998	874		20	44	44	136	4
5	ELEVATOR	1998	85,458		20	4,273	4,273	14,243	5
6	BUILDING WORK	1998	41,520		20	2,076	2,076	8,532	6
7	RAILS AND STAIRS	1998	8,000		20	400	400	1,300	7
8	SPRINKLER SYSTEM	1998	7,390		20	370	370	1,388	8
9	SMOKE DAMPER	1998	2,770		20	139	139	521	9
10	SHEET METAL	1998	7,118		20	356	356	1,187	10
11	FIRE DAMPERS	1998	336		20	17	17	55	11
12	ROOFING	1998	3,550		20	178	178	623	12
13	BRONZE DOORS	1998	1,700		20	85	85	319	13
14	BRONZE DOORS	1998	6,300		20	315	315	998	14
15	A/C INSTALL	1998	16,275		20	814	814	2,781	15
16	H20 PROOF SEALER	1998	5,600		20	280	280	980	16
17	HEATING UNIT	1998	23,485		20	1,174	1,174	3,913	17
18	NURSE CALL SYSTEM	1998	7,003		20	350	350	1,465	18
19	BUILDING IMPROV	1998	21,923		20	1,096	1,096	4,110	19
20	INSULATION	1998	3,650		20	183	183	686	20
21	HEATING	1998	1,025		20	51	51	183	21
22	ROOF REPAIR	1998	1,600		20	80	80	260	22
23	CARPENTRY WORK	1998			20				23
24	Carpentry Work	1998	3,989		20	199	199	647	24
25	Carpentry Work	1998			20				25
26	PAINTING	1998	607		20	30	30	60	26
27	PAINTING	1998	999		20	50	50	100	27
28	ELEVATOR FRAMES	1999	545		20	27	27	54	28
29	REPAIR WORK	1999	1,000		20	50	50	100	29
30	LIGHTING SUPPLIES	1999	1,309		20	65	65	130	30
31	KRAFT INSULATION	1999	1,916		20	96	96	192	31
32	PLASTER BOARD	1999	2,440		20	122	122	244	32
33	PLASTER BOARD	1999	1,163		20	58	58	116	33
34	TOTAL (lines 1 thru 33)		$ 3,555,199	$ 64,803		$ 154,067	$ 89,264	$ 2,262,901	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,555,199	$ 64,803		$ 154,067	$ 89,264	$ 2,262,901	1
2	PANEL AT LAUNDRY RM	1999	1,102		20	55	55	110	2
3	LIGHTING SUPPLIES	1999	618		20	31	31	62	3
4	ELEVATOR REPAIRS	1999	553		20	28	28	56	4
5	LIGHTING SUPPLIES	1999	1,261		20	63	63	126	5
6	(8) 4SP MOTORS	1999	628		20	31	31	62	6
7	LOBBY LEVELING	1999	1,480		20	74	74	148	7
8	GENERATOR REPAIRS	1999	675		20	34	34	68	8
9	CONTROL BOARD	1999	1,861		20	93	93	186	9
10	MIX CEMENT	1999	4,650		20	233	233	466	10
11	ELECTRICAL SUPPLIES	1999	608		20	30	30	60	11
12	LANDSCAPING	1999	6,417		20	321	321	642	12
13	TOILET SUPPLIES	1999	822		20	41	41	82	13
14	HADN RAILINGS	1999	2,150		20	108	108	216	14
15	REPAIR CONTROL	1999	941		20	47	47	94	15
16	CHILLER	1999	850		20	43	43	86	16
17	TILES/ELECTRICAL	1999	719		20	36	36	72	17
18	CEILING MATERIALS	1999	885		20	44	44	88	18
19	REPAIR WALK-IN REFRI	1999	2,300		20	115	115	230	19
20	SWING DOORS	1999	944		20	47	47	94	20
21	METAL DOOR	1999	1,003		20	50	50	100	21
22	BIRCH PLYWOOD	1999	2,573		20	129	129	258	22
23	CTN 2X2 CHEYENE	1999	1,988		20	99	99	198	23
24	CONCRETE PAD	1999	900		20	45	45	90	24
25	LANDSCAPING	1999	1,125		20	56	56	112	25
26	TILES	1999	1,217		20	61	61	122	26
27	REPAIR WORK	1999	1,451		20	73	73	146	27
28	INSULATION	1999	1,500		20	75	75	150	28
29	CARPETING	1999	630		20	32	32	64	29
30	DOOR LOCKS	1999	629		20	31	31	62	30
31	REPAIR DOOR CHILLER	1999	2,900		20	145	145	290	31
32	REPAIR EXHAUSTION	1999	1,019		20	51	51	102	32
33	FAN COIL	1999	2,685		20	134	134	268	33
34	TOTAL (lines 1 thru 33)		$ 3,604,283	$ 64,803		$ 156,522	$ 91,719	$ 2,267,811	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,604,283	$ 64,803		$ 156,522	$ 91,719	$ 2,267,811	1
2	REMOVE FAN COILS	1999	6,520		20	326	326	652	2
3	WOOD PRODUCTS	1999	3,353		20	168	168	336	3
4	TILES CEILING	1999	1,234		20	62	62	124	4
5	ELECTRICAL SUPPLIES	1999	1,595		20	80	80	160	5
6	SCHLAGE LOCKS	1999	1,557		20	78	78	156	6
7	SCHLAGE LOCKS	1999	1,142		20	57	57	114	7
8	ELECTRICAL	1999	590		20	30	30	60	8
9	BLINDS	1999	2,352		20	118	118	236	9
10	PAINTS	1999	816		20	41	41	82	10
11	TILES/GROUT	1999	2,794		20	140	140	280	11
12	MACHINE RENTAL FOR C	1999	1,628		20	81	81	162	12
13	ELEVATOR REPAIRS	1999	1,448		20	72	72	144	13
14	SPRINKLER	1999	3,381		20	169	169	338	14
15	CHILLER	1999	2,235		20	112	112	224	15
16	CHILLER	1999	1,450		20	73	73	146	16
17	CALL SYSTEM	1999	1,030		20	52	52	104	17
18	METAL DOORS	1999	12,476		20	624	624	1,248	18
19	TILES/SLABS	1999	26,862		20	1,343	1,343	2,686	19
20	AC REPAIRS	1999	1,919		20	96	96	192	20
21	CHANDELEIR	1999	8,374		20	419	419	838	21
22	ELECTRICAL	1999	478		20	24	24	48	22
23	FIRE ALARM SYSTEM	1999	24,144		20	1,207	1,207	2,414	23
24	ADD'L ELECTRICAL	1999	18,700		20	935	935	1,870	24
25	SPRINKLER ADDITION	1999	3,105		20	155	155	310	25
26	ADD'L ELECTRICAL	1999	2,570		20	129	129	258	26
27	SPRINKLER ADDITION	1999	4,976		20	249	249	498	27
28	MACHINE RENTAL FOR C	1999	4,529		20	226	226	452	28
29	PLYWOOD	1999	3,491		20	175	175	350	29
30	WOOD TRIM	1999	3,639		20	182	182	364	30
31	WOOD TRIM	1999	573		20	29	29	58	31
32	DOORS	1999	856		20	43	43	86	32
33	OAK RAIL	1999	4,843		20	242	242	484	33
34	TOTAL (lines 1 thru 33)		$ 3,758,943	$ 64,803		$ 164,259	$ 99,456	$ 2,283,285	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 3,758,943	$ 64,803		$ 164,259	$ 99,456	$ 2,283,285	1
2	OAK RAIL	1999	3,418		20	171	171	342	2
3	ELECTRICAL	1999	2,500		20	125	125	250	3
4	WATER CHILLER	1999	29,315		20	1,466	1,466	2,932	4
5	AC UNIT	1999	1,650		20	83	83	166	5
6	ELECTRICAL	1999	3,516		20	176	176	352	6
7	GRANITE RECEPTION DE	1999	3,539		20	177	177	354	7
8	TILES/SLABS	1999	1,181		20	59	59	118	8
9	INSULATION	1999	1,500		20	75	75	150	9
10	REPAIR WORK	1999	1,500		20	75	75	150	10
11	GLASS & MIRROR	1999	1,160		20	58	58	116	11
12	HEATING & COOLING UN	1999	10,481		20	524	524	1,048	12
13	AC REPAIRS	1999	695		20	35	35	70	13
14	METAL DOORS	1999	1,975		20	99	99	198	14
15	BLINDS	1999	1,746		20	87	87	174	15
16	LIGHTING FIXTURES	1999	3,313		20	166	166	332	16
17	SPRINKLER	1999	3,408		20	170	170	340	17
18	SWING DOORS	1999	1,172		20	59	59	118	18
19	BLINDS	1999	266		20	13	13	26	19
20	BLINDS	1999	2,086		20	104	104	208	20
21	BLINDS	1999	4,146		20	207	207	414	21
22	ARCHITECT FEES	1999	3,369		20	168	168	336	22
23	ANNEX ADDITION	1999	93,480		20	4,674	4,674	9,348	23
24	FIRE EQUIPMENT	2000	17,038		20	852	852	923	24
25	WIRING	2000	1,600		20	80	80	87	25
26	SPRINKLER PROJECT	2000	3,381		20	169	169	183	26
27	FIXTURES	2000	767		20	38	38	41	27
28	FENCE	2000	550		20	28	28	30	28
29	FIRE PROOFING	2000	1,010		20	51	51	55	29
30	FIRE DETECTION SYSTM	2000	625		20	31	31	34	30
31	MASTER BOX	2000	1,090		20	55	55	60	31
32	ROOF REPAIRS	2000	22,260		20	1,113	1,113	1,206	32
33	SPRINKLER REPAIRS	2000	1,107		20	55	55	60	33
34	TOTAL (lines 1 thru 33)		$ 3,983,787	$ 64,803		$ 175,502	$ 110,699	$ 2,303,506	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 3,983,787	$ 64,803		$ 175,502	$ 110,699	$ 2,303,506	1
2	CONCRETE WORK	2000	2,450		20	123	123	133	2
3	BLINDS	2000	2,474		20	124	124	134	3
4	TEST HEADER	2000	5,656		20	283	283	307	4
5	MICROPROCESSOR	2000	3,890		20	195	195	211	5
6	BLOCK SEALER	2000	5,736		20	287	287	311	6
7	SHUTTERS	2001	2,656		20	133	133	133	7
8	SHUTTERS	2001	1,180		20	59	59	59	8
9	HANDRAILS	2001	1,665		20	83	83	83	9
10	ELEVATOR	2001	27,500		20	1,375	1,375	1,375	10
11	VERTICAL BLINDS	2001	2,150		20	108	108	108	11
12	TILE	2001	2,450		20	123	123	123	12
13	STEAM TABLE COVERS	2001	1,850		20	93	93	93	13
14	HEAT EXCHANGER	2001	1,740		20	87	87	87	14
15	ELECTRICAL	2001	1,150		20	58	58	58	15
16	DOOR SYSTEM	2001	5,485		20	274	274	274	16
17	VERTICAL BLINDS	2001	2,216		20	111	111	111	17
18	DOOR SYSTEM	2001	1,500		20	75	75	75	18
19	FIRE AND SECURITY SYSTEM	2001	5,165		20	258	258	258	19
20	FENCE AND DRIVE GATE	2001	2,450		20	123	123	123	20
21	VERTICAL BLINDS	2001	3,281		20	164	164	164	21
22	DRIVE UNIT	2001	3,700		20	185	185	185	22
23	VERTICAL BLINDS	2001	1,875		20	94	94	94	23
24	ELECTRICAL	2001	16,320		20	816	816	816	24
25	HANDRAIL	2001	650		20	33	33	33	25
26	HOT WATER UNIT	2001	550		20	28	28	28	26
27	BURNER REPAIRS	2001	710		20	36	36	36	27
28	POWER VENTER	2001	795		20	40	40	40	28
29	CEILING TILES	2001	3,026		20	151	151	151	29
30	CEILING FAN	2001	696		20	35	35	35	30
31	CONCRETE WORK	2001	875		20	44	44	44	31
32	CEILING TILES	2001	666		20	33	33	33	32
33	LIGHT FIXTURES	2001	540		20	27	27	27	33
34	TOTAL (lines 1 thru 33)		$ 4,096,834	$ 64,803		$ 181,156	$ 116,353	$ 2,309,244	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 4,096,834	$ 64,803		$ 181,156	$ 116,353	$ 2,309,244	1
2	FENCE	2001	725		20	36	36	36	2
3	AC REPAIRS	2001	530		20	27	27	27	3
4	ROOF REPAIRS	2001	1,450		20	73	73	73	4
5	HEATER BOOSTER	2001	591		20	30	30	30	5
6	ROOF REPAIRS	2001	1,400		20	70	70	70	6
7	ELECTRICAL REPAIRS	2001	962		20	48	48	48	7
8	PIPE WORK	2001	1,375		20	69	69	69	8
9	LIGHT FIXTURES	2001	1,086		20	54	54	54	9
10	PUMP	2001	551		20	28	28	28	10
11	CEILING TILES	2001	1,160		20	58	58	58	11
12	MOTOR	2001	602		20	30	30	30	12
13	PAINTING	2001	676		20	34	34	34	13
14	CEILING TILES	2001	1,102		20	55	55	55	14
15	BATHROOM REMODEL	2001	2,737		20	137	137	137	15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,111,781	$ 64,803		$ 181,903	$ 117,100	$ 2,309,991	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 4,111,781	$ 64,803		$ 181,903	$ 117,100	$ 2,309,991	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,111,781	$ 64,803		$ 181,903	$ 117,100	$ 2,309,991	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1988		$ 55,321	$ 2,012	35	$ 1,581	$ (431)	$ 9,484	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	ALLOC-MADO MANAGEMENT			1995	1,283	256	20	65	(191)	418	9
10	ALLOC-MADO MANAGEMENT			1993	21,072	561	20	1,054	493	8,876	10
11	ALLOC-MADO MANAGEMENT			2000	3,151	-	20	158	158	240	11
12	ALLOC-MADO MANAGEMENT			2001	1,365	-	20	50	(50)	50	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
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57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 82,192	$ 2,829		$ 2,908	$ (21)	$ 19,068	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 621,763	$ 46,612	$ 45,407	$ (1,205)	10	$ 253,570	71
72	Current Year Purchases	22,694	4,553	2,150	(2,404)	10	2,150	72
73	Fully Depreciated Assets	3,100				10	3,100	73
74								74
75	TOTALS	$ 647,557	$ 51,165	$ 47,557	$ (3,609)		$ 258,820	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1995 JEEP LAREDO	1995	$ 25,368	$ 1,775	$	$ (1,775)	5	$ 18,321	76
77										77
78										78
79										79
80	TOTALS			$ 25,368	$ 1,775	$	$ (1,775)		$ 18,321	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	4,859,956	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	117,743	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	229,460	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	111,717	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	2,587,132	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☒ YES ☐ NO

16. Rental Amount for movable equipment: $ 14,004 Description: SEE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 01	hrs	$ 15,962		$	$		$ 15,962	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			157,210			157,210	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				160,372		160,372	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):			20,442			223,576		244,018	13
14	TOTAL			$ 36,404		$ 157,210	$ 383,948		$ 577,562	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 5,059	$ 6,059	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,880,547	1,880,547	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	37,774	37,774	6
7	Other Prepaid Expenses	1,248	1,248	7
8	Accounts Receivable (owners or related parties)	2,624,284	6,317,122	8
9	Other(specify): See supplemental schedule	15,667	15,667	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,564,579	$ 8,258,417	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost		424,750	14
15	Leasehold Improvements, at Historical Cost	3,453,332	3,460,625	15
16	Equipment, at Historical Cost	177,739	1,158,681	16
17	Accumulated Depreciation (book methods)	(1,624,191)	(4,331,138)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		48,587	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(48,587)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		1,288,774	22
23	Other(specify): See supplemental schedule		17,939	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,006,880	$ 2,019,631	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,571,459	$ 10,278,048	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 2,279,630	$ 2,279,630	26
27	Officer's Accounts Payable		1,075,773	27
28	Accounts Payable-Patient Deposits	19,618	19,618	28
29	Short-Term Notes Payable	8,000	2,961,622	29
30	Accrued Salaries Payable	62,427	62,427	30
31	Accrued Taxes Payable (excluding real estate taxes)	241	241	31
32	Accrued Real Estate Taxes(Sch.IX-B)	242,639	242,639	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	(11,094)	(11,094)	35
	Other Current Liabilities(specify):			
36	See supplemental schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,601,461	$ 6,630,856	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	5,237,762	5,237,762	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,237,762	$ 5,237,762	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,839,223	$ 11,868,618	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,267,764)	$ (1,590,570)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,571,459	$ 10,278,048	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (731,240)	1	
2	Restatements (describe):		2	
3	INCOME RESTATEMENT	(103,710)	3	
4	EXPENSE RESTATEMENT	174,674	4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (660,276)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(607,488)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (607,488)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,267,764)	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,375,343	1
2	Discounts and Allowances for all Levels	(215,550)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,159,793	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	787,100	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 787,100	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,154	12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	272,309	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	15,812	19
20	Radiology and X-Ray	6,101	20
21	Other Medical Services	109,241	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 404,617	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	683	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 683	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	2,850	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,850	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,355,043	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,054,297	31
32	Health Care	3,177,478	32
33	General Administration	1,259,615	33
	B. Capital Expense		
34	Ownership	775,543	34
	C. Ancillary Expense		
35	Special Cost Centers	587,741	35
36	Provider Participation Fee	107,857	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,962,531	40
41	**Income before Income Taxes (line 30 minus line 40)****	(607,488)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (607,488)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,663	5,663	131,050	23.14	3
4	Licensed Practical Nurses	2,570	2,594	40,708	15.69	4
5	Nurse Aides & Orderlies	113,469	123,746	871,299	7.04	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	834	881	36,404	41.32	7
8	Rehab/Therapy Aides	6,428	6,798	95,623	14.07	8
9	Activity Director	2,004	2,065	17,281	8.37	9
10	Activity Assistants	39,912	41,648	255,922	6.14	10
11	Social Service Workers	9,488	10,584	102,217	9.66	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	7,324	7,888	82,305	10.43	17
18	Housekeepers	1,974	2,080	20,524	9.87	18
19	Laundry					19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,673	6,013	43,149	7.18	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	195,339	209,960	$ 1,696,482 *	$ 8.08	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	263	$ 6,569	01-03	35
36	Medical Director	80	5,040	09-03	36
37	Medical Records Consultant	monthly	4,032	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	600	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	40	3,625	10a-03	41
42	Respiratory Therapy Consultant	526	15,765	10a-03	42
43	Speech Therapy Consultant				43
44	Activity Consultant	94	2,397	11-03	44
45	Social Service Consultant	63	3,448	12-03	45
46	Other(specify)				46
47	SEE ATTACHED		472,596		47
48					48
49	TOTAL (lines 35 - 48)	1,066	$ 514,072		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	7,158	$ 1,161,773	10-03	50
51	Licensed Practical Nurses	58,265	299,242	10-03	51
52	Nurse Aides	3,103	46,789	10-03	52
53	TOTAL (lines 50 - 52)	68,526	$ 1,507,804		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$

B. Administrative - Other

Description	Amount
Management Fees - MADO MANAGEMENT	$ 620,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 620,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Maemar	Architectural Consultant	$ 1,850
Personnel Planners	Unemployment Consultant	1,398
Wolf & Co	Accountants	3,000
Frost, Ruttenberg & Rothblatt	Accountants	21,952
Rock, Fuso & Garvey	Real Estate Tax Analyst	452
Hynes, Johnson and Macnamara	Legal	38,104
Health Data Systems	Data Processing	7,707
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 74,463

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 26,092
Unemployment Compensation Insurance	24,239
FICA Taxes	129,724
Employee Health Insurance	5,948
Employee Meals	51,626
Illinois Municipal Retirement Fund (IMRF)*	
401K	489
TOTAL (agree to Schedule V, line 22, col.8)	$ 238,118

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,561
Health Care Worker Background Check	1,441
(Indicate # of checks performed 132)	
Employee Recruitment	6,000
Licenses and Fees	3,559
Alloc-MADO	7,917
Alloc-Bldg Company	50
Less: Public Relations Expense	
Non-allowable advertising	
Yellow page advertising	
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,528

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,119
Alloc-MADO	126
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,245

**See instructions.

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
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9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number ST AGNES MANOR INC. # 0027870 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **56,563** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **107,857**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **51,626** Has any meal income been offset against related costs? **NO** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100% of In**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees